	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345412	B. WING			03/21/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
				1038 COLLEGE STREET			
BRANIW	OOD NH & RETIREME			OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 558 SS=D	Reasonable Accom CFR(s): 483.10(e)(	modations Needs/Preferences 3)	F 5	58		4/18/18	
	services in the facili accommodation of i preferences except endanger the health other residents. This REQUIREMEN by: Based on record re- interview and staff i place a call light (Re- allow for the resider needed for one of or accommodation of i The findings include Resident #12 was a 6/15/17 and re-adm diagnoses including weakness. Review of the most Data Set Assessme Resident #12 as mo with a Brief Intervie He had no behavior hearing was adequa understood others a He required extensi assistance with bec- person assistance of	Arrow of the resident arrow, the facility failed to resident #12) within reach to not to request staff assistance if one resident reviewed for needs.		<ol> <li>The call bell was p for resident #12 on 3/2 of Nursing.</li> <li>A 100 % audit of a include resident #12, w the facility patient care director of activities an office manager to ensu individual needs and p preferences were by er residents and call bells w allow the residents to ca as needed. All call bells reach during the time ca identified areas of cond 3. 100% of all staff to nursing staff, certified r to include NA #12 are f the clinical nurse mana Director of Nursing reg that residents all bell n-service initiated on 3 completed by 4/6/18.</li> <li>The Clinical Nurse Coordinator, and Treat</li> </ol>	1/18 by the Director II residents, to vas conducted by coordinator, d facility business ire residents ersonal nsuring the ere within reach to call for assistance s were placed in of the audit for any cern by the auditor. o include licensed hursing assistants to be in-serviced by ager and/or facility arding ensuring IIs are within reach. 3/21/17 to be		
		Area Assessment dated elated to the resident requiring		observations to include ensure call bells are wi reach utilizing a Cather	ithin resident⊡s		

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

03/30/2018

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 04/24/20 APPROVE . 0938-039
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE COMPI	SURVEY
		345412	B. WING		03/2	21/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē	
	OOD NH & RETIREMEN	TCENT		1038 COLLEGE STREET		
DRANIW		CENT		OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 558	Continued From pag	e 1	F 55	8		
		e with bed mobility and	1 00	Tool 5 x week, to include weel	kends v 1	
	supervision for transf	,		weeks, weekly x 4 weeks ther		
				months to ensure staff are pro		
	Review of the care p	lan for resident has a focus		bathing assistance to ensure t		
	-	tivities of Daily Living (ADL)		catheter is covered and place	-	
	self-care performanc			that promotes dignity and infe		
		ke with left sided weakness. Id: call light within reach with		for the resident. Any concerns immediately addressed by the		
		he current level of function		Nursing Manager, Nursing Ed		
	through the review da			Coordinator, and Treatment N		
				re-education of staff during the		
	During an observatio	on on 3/20/18 at 3:24 PM the		audit. The DON will review an	d initial the	
	call light was under t	he bed on the floor.		audit tool weekly x 8 weeks th x 2 months to ensure complia		
	-	with Resident #12 on 3/20/18		DON will compile the results of		
		I he could use his call bell but		Resident Bathing Audit Tool a		
	If it was not in reach	he would holler for the nurse.		to the Executive Quality Impro		
	During an observatio	on on 3/21/18 at 10:09 AM the		Committee monthly x 4 month Identification of trends will det		
	call light was under t			need for further action and/or		
	5			frequency of required monitor	-	
		with Nursing Assistant #2 on			-	
		she stated the call bell				
	should be in reach of	f the resident.				
	During an interview	with the Director of Nursing				
	on 3/21/18 at 11:16 A					
		I would be in reach and not				
	on the floor.					
	During an interview v	with the Administrator on				
	-	she stated the call bell				
	should not be on the					
F 623 SS=B	Notice Requirements CFR(s): 483.15(c)(3)	s Before Transfer/Discharge )-(6)(8)	F 62	3		4/18/18
	§483.15(c)(3) Notice					
	Before a facility trans	sters or discharges a				

Facility ID: 943195

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CENTER	S FOR MEDICARE &						FORM OMB NC	): 04/24/2018 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		345412	B. WING				03/:	21/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
BRANTW	OOD NH & RETIREMENT	CENT			038 COLLEGE STREET DXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 623	the reasons for the m language and manner facility must send a correpresentative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(f (D) An immediate tran required by the reside under paragraph (c)(f	and the resident's he transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or ider this section must be t least 30 days before the l or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, l)(i)(B) of this section;	F	623				

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			()(0)		0.00	<u>10. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345412	B. WING		0	3/21/2018
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	CENT		1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 3	F 623	3		
	notice specified in pa must include the follo (i) The reason for tra (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omt (vi) For nursing facility and developmental disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dis email address and tel agency responsible for advocacy of individual	nsfer or discharge; of transfer or discharge; nich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which ts; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State oudsman; y residents with intellectual isabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder e Protection and Advocacy				
		es to the notice. ne notice changes prior to or discharge, the facility				

Facility ID: 943195

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		345412	B. WING		03	/21/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTW	OOD NH & RETIREMENT	CENT		1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 623	as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prit to the State Survey A State Long-Term Carr the facility, and the re- well as the plan for the relocation of the resident 483.70(1). This REQUIREMENT by: Based on record revision interviews, the facility resident and resident notification for the reac hospital for 4 of 4 res hospitalization. (Resident Resident #68 and Re- The findings included Example 1. Resident #5 was adm 7/25/14 and re-admitti with diagnoses included Neoplasm of the liver Review of Resident # 1/30/18 she was trans surgical consult and a	in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § is not met as evidenced ew and family and staff failed to provide the representative a written ison for transfer to the idents reviewed for dent #5, Resident #38, sident #34) : initted to the facility on ed on 2/7/18 and 3/15/18 ing Heart Failure and 5's most recent minimum dated 9/16/17 identified rately cognitively impaired.	F 623	<ol> <li>The Nursing Home Notice of Transfer/Discharge form been provi for use by the Patient Care Coordin or back-up personnel, following resi transfers to the acute care setting.</li> <li>The facility Patient Care Coordi and Director of Activities were in-se on 3/21/2018 regarding the expecta preparing Nursing Home Notice of Transfer/Discharge form to be maile all Resident Representatives followit transfer to an acute care setting witt copy provided to facility Administrate 100% in-service was initiated by the facility clinical nurse manager on 3/21/2018, to be completed by 4/6/2 with no staff working beyond this da have not yet received the education licensed nurses regarding the expect that the Transfer Resident Summary is completed for all resident transfer the attached Bed Hold Policy provid the resident s transfer packet.</li> </ol>	ator, dent inator rviced tion of ed to ing h a or. A e 2018 te who h, for all ctation y Form rs with		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/24/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345412	B. WING		03/21/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRANTW	OOD NH & RETIREMENT	CENT		1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 623	been provided to the representative. Further review of Res 3/6/18 she was transf change in condition re written notice of trans been provided to the representative. During an interview w 3/20/18 10:02 AM she that a notice needed resident representative hospital. During an interview w 3/20/18 at 10:30 AM not been sending not resident representative transferred to the hose corrected immediately During a family interve the family member star received any type of the was transferred to the 3/6/18. Example 2. Resident #38 was ad 7/28/17 and re-admitt 2/3/18 and 3/7/18 witt chronic gastrointestin	resident or resident sident #5's chart revealed on ferred to the hospital for a elated to bleeding. No offer was documented to have resident or resident with the Social Worker on e stated she was not aware to be given to the resident or ve when transferring to the when transferring to the when the resident or ve when the resident or ve when the resident or ve when the resident spital but this would be y. iew on 3/20/18 at 11:00 AM ated that she had not notice when Resident #5 e hospital on 1/30/18 and mitted to the facility on ted on 1/9/18, 1/14/18, h diagnoses including al bleeding. 38's most recent minimum	F 62	3. The Facility Administrator will audits via the Notification Audit too 100% of residents transferred from facility to ensure that this system i effective weekly x 8 weeks, bi-wee weeks, then monthly x 2 months. A concerns will be immediately addr by the medical record manager, P Care Coordinator and Director of A with re-education of the pertinent a during the time of the audit. The Administrator will compile the result the Notification Audit Tool and presente Executive Quality Improvemer Committee monthly x 5 months. Identification of trends will determineed for further action and/or char frequency of required monitoring.	ol of n the s ekly x 4 Any ressed vatient Activities staff ults of sent to nt ine the

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		345412	B. WING			03/	/21/2018	
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
BRANTW	OOD NH & RETIREMENT	CENT			1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 623	cognitively intact. Review of Resident # 12/26/17 she was tran critical lab result whice to the hospital. On 1/1 again transferred to the and admitted. On 1/1 revealed she was trans shortness of breath. Of was transferred to the On 3/20/18 Resident to the hospital for a cl were no written notice have been provided to representative. During an interview w 3/19/18 at 9:07 AM he Resident #38 had had since January 2018 fo He stated he had not related to her hospital During an interview w 3/20/18 10:02 AM she that a notice needed resident representative hospital. During an interview w 3/20/18 at 10:30 AM she that a notice needed for the she that an other the she that an other the she that an the sh	38's chart revealed on hsferred to the hospital for a h resulted in an admission (3/18 Resident #38 was he hospital for evaluation 11/18 Resident #38's chart hsferred to the hospital for On 1/26/18 Resident #38 e hospital for active bleeding. #38 was again transferred hange in condition. There es of transfer documented to to the resident or resident with the family member on e stated he visited daily and d multiple hospital admission for gastrointestinal bleeding. received any paperwork I transfers. With the Social Worker on e stated she was not aware to be given to the resident or when transferring to the when transferring to the when the resident or we when the resident pital but this would be	F	623	3			

Facility ID: 943195

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/24/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>				(X3) DATE	
		345412	B. WING			_	03/	21/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
BRANTWO	DOD NH & RETIREMENT	CENT			038 COLLEGE STREET DXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	97	F	623				
	Example #3.							
	11/21/17 and re-admi 1/11/18 with diagnose Urinary tract infection Review of the admiss assessment dated 11 #68 as having long ar problems and severel Review of Resident # transferred to the hos Bradycardia and trans 1/8/18 for Bronchitis. notices of transfer doo provided to the reside representative. During an interview w 3/20/18 10:02 AM she that a notice needed to resident representative hospital. During an interview w 3/20/18 at 10:30 AM sho	es including Dementia, and femur fracture. ion minimum data set /28/17 identified Resident nd short term memory ly cognitively impaired. 68's chart revealed she was pital on 12/25/17 for sferred to the hospital on There were no written cumented to have been ent or resident with the Social Worker on e stated she was not aware to be given to the resident or we when transferring to the when transferring to the when the resident or we when the resident or we we w						

Facility ID: 943195

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345412	B. WING			03/	21/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRANTWO	OOD NH & RETIREMENT	CENT			1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	12/14/15 and re-admi re-admitted on 1/18/1 Heart Failure, Hyperte Accident, Dementia a Pulmonary Disease. Review of Resident # Data Set (MDS) 10/24 as moderately cogniti Review of Resident # 1/4/18 he was transfe critical lab value. No v documented to have I resident or representa Further review of Res on 1/18/18 he was tra change in condition re clots. No written notic documented to have I resident or resident re clots. No written notic documented to have I resident or resident re During an interview w 3/20/18 at 10:02 AM s aware that a notice ne resident or resident re transferring to the hos	Imitted to the facility on tted on 1/4/18 and 8 with diagnoses including ension, Cerebral Vascular nd Chronic Obstructive 34' s most recent Minimum 4/17 identified Resident # 34 vely impaired. 34 ' s chart revealed on rred to the hospital due to a written notice of transfer was been provided to the ative. ident # 34 ' s chart revealed unsferred to the hospital for a elated to a condition of blood be of transfer was been provided to the epresentative. ith the Social Worker on she stated she was not eeded to be given to the epresentative when spital.	F	623			
	transferred to the hos corrected immediately	-					

If continuation sheet Page 9 of 22

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB         Ad5412         NAME OF PROVIDER OR SUPPLIER         BRANTWOOD NH & RETIREMENT CENT         (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI REGULATORY OR LSC IDENTIFYING INFORMATI A phone interview was attempted with Resid 34 's resident representative on 3/21/18 at ' AM with a message left to return the call. Th resident 's representative did not return the SS=B         F 625         Notice of Bed Hold Policy Before/Upon Trns SS=B         CFR(s): 483.15(d)(1)(2)         §483.15(d) Notice of bed-hold policy and ret spacifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	CLIA (X2) MUL ER: A. BUILD B. WING JLL ID PREF TAG	STREET ADDRESS, CITY, STAT 1038 COLLEGE STREET OXFORD, NC 27565 PROVIDER'S P FIX (EACH CORRECT G CROSS-REFERENCE	(X3) DATE S COMPL 03/2	
NAME OF PROVIDER OR SUPPLIER         BRANTWOOD NH & RETIREMENT CENT         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FURE REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION A phone interview was attempted with Reside 34 ' s resident representative on 3/21/18 at ' AM with a message left to return the call. The resident ' s representative did not return the Notice of Bed Hold Policy Before/Upon Trms CFR(s): 483.15(d)(1)(2)         §483.15(d) Notice of bed-hold policy and ret \$483.15(d)(1) Notice before transfer. Before nursing facility transfers a resident to a hosp the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	JLL PREF ION) TAG	STREET ADDRESS, CITY, STAT 1038 COLLEGE STREET OXFORD, NC 27565 PROVIDER'S P FIX (EACH CORRECT G CROSS-REFERENCE	PLAN OF CORRECTION	21/2018
BRANTWOOD NH & RETIREMENT CENT         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION A phone interview was attempted with Reside 34 ' s resident representative on 3/21/18 at ' AM with a message left to return the call. The resident ' s representative did not return the Notice of Bed Hold Policy Before/Upon Trns SS=B         F 625       CFR(s): 483.15(d)(1)(2)         §483.15(d) Notice of bed-hold policy and ret §483.15(d)(1) Notice before transfer. Before nursing facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informat the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	JLL PREF ION) TAG	1038 COLLEGE STREET OXFORD, NC 27565 PROVIDER'S P FIX (EACH CORRECT G CROSS-REFERENC	PLAN OF CORRECTION	
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FURE REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION A phone interview was attempted with Reside 34 ' s resident representative on 3/21/18 at comparison AM with a message left to return the call. The resident ' s representative did not return the Notice of Bed Hold Policy Before/Upon Trns SS=B         F 625       Notice of Bed Hold Policy Before/Upon Trns SS=B         CFR(s): 483.15(d)(1)(2)         §483.15(d) Notice of bed-hold policy and ret section goes on therapeutic leave, the nursing facility transfers a resident to a hosp the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	JLL PREF ION) TAG	OXFORD, NC 27565 PROVIDER'S P FIX (EACH CORRECT G CROSS-REFERENC		
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FURE REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION A phone interview was attempted with Reside 34 ' s resident representative on 3/21/18 at comparison AM with a message left to return the call. The resident ' s representative did not return the Notice of Bed Hold Policy Before/Upon Trns SS=B         F 625       Notice of Bed Hold Policy Before/Upon Trns SS=B         CFR(s): 483.15(d)(1)(2)         §483.15(d) Notice of bed-hold policy and ret section goes on therapeutic leave, the nursing facility transfers a resident to a hosp the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	JLL PREF ION) TAG	PROVIDER'S P FIX (EACH CORRECT G CROSS-REFERENC		
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION         F 623       Continued From page 9         A phone interview was attempted with Residents 34 's resident representative on 3/21/18 at 'A M with a message left to return the call. Theresident 's representative did not return the CF 625         SS=B       CFR(s): 483.15(d)(1)(2)         §483.15(d) Notice of bed-hold policy and returning facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informate the resident or resident representative that specifies- <ul> <li>(i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</li> </ul>	JLL PREF ION) TAG	FIX (EACH CORRECT G CROSS-REFERENC		
A phone interview was attempted with Resid 34 's resident representative on 3/21/18 at ' AM with a message left to return the call. Th resident 's representative did not return the Notice of Bed Hold Policy Before/Upon Trns SS=B CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and ret §483.15(d)(1) Notice before transfer. Before nursing facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informat the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;		DE	CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
A phone interview was attempted with Resid 34 's resident representative on 3/21/18 at AM with a message left to return the call. Th resident 's representative did not return the Notice of Bed Hold Policy Before/Upon Trns SS=B CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and ret §483.15(d)(1) Notice before transfer. Before nursing facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informat the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	I F	623		
SS=BCFR(s): 483.15(d)(1)(2)§483.15(d) Notice of bed-hold policy and ret§483.15(d)(1) Notice before transfer. Before nursing facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informat the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;	lent # 10:35 he call.			
<ul> <li>§483.15(d)(1) Notice before transfer. Before nursing facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informat the resident or resident representative that specifies-</li> <li>(i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;</li> </ul>	fr F	625	•	4/18/18
<ul> <li>nursing facility transfers a resident to a hosp the resident goes on therapeutic leave, the nursing facility must provide written informat the resident or resident representative that specifies-</li> <li>(i) The duration of the state bed-hold policy, any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the st plan, under § 447.40 of this chapter, if any;</li> </ul>	urn-			
<ul> <li>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent paragraph (e)(1) of this section, permitting a resident to return; and</li> <li>(iv) The information specified in paragraph (e) of this section.</li> </ul>	oital or ion to if o ate with e)(1)			
§483.15(d)(2) Bed-hold notice upon transfer the time of transfer of a resident for hospitalization or therapeutic leave, a nursin facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidence by:	ıg			
Based on record review and interviews, the		1. The facility Tran	sfer Resident	

Facility ID: 943195

If continuation sheet Page 10 of 22

					OMB NO.	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		345412	B. WING		03/2	1/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
BRANTW	OOD NH & RETIREMEN	T CENT		1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 625	Continued From pag	e 10	F 62	5		
	facility failed to provide 4 of 4 residents with written notice of the bed hold policy upon a resident's transfer to the hospital (Resident #5, #38, #68 and #34).			Summary Form was adj Administrator on 3/20/20 new criterion of providin the official Bed Hold Pol from the facility to an ac	018 to reflect a g the resident with icy upon transfer	
	The findings included Example 1.	d:		All new clinical hard cha prepared by facility med manager with the Bed H attached to the Transfer	ical records old Policy	
	Resident #5 was admitted to the facility on 7/25/14 and re-admitted on 2/7/18 and 3/15/18 with diagnosis including heart failure and neoplasm of the liver. She was transferred to the hospital on 1/30/18 and 3/6/18. A review of Resident #5's Significant Change Minimum Data Set Assessment dated 9/6/17		Summary Form. 2. 100% of resident is be updated with the new Summary Form with the hold policy by 3/31/2018	/ Transfer attached bed		
	identified Resident # impaired.	5 as moderately cognitively		3. The facility Patient ( and Director of Activities on 3/21/2018 regarding	were in-serviced	
	A review of Resident indicated Resident # family member.	#5's medical record 5's responsible party was a		preparing Post-Transfer Letters to be mailed to a Representatives followir acute care setting with a	II Resident ng transfer to an	
	During an interview with the Social Worker on 3/20/18 at 10:02 AM she stated the resident or responsible party was given a copy of the Bed Hold policy on admission. She stated she was unaware that a Bed Hold notice needed to be given to the resident or responsible party when the resident transferred to the hospital. She stated she usually called the family member once she was made aware the resident would be admitted to the hospital. She stated the facility had always had enough beds to re-admit a			facility Administrator. A <sup>2</sup> was initiated by the facil manager on 3/21/2018, by 4/6/2018 with no staf this date who have not y education, for all license regarding the expectatio Transfer Resident Sumr completed for all resider the attached Bed Hold F the resident □s transfer	100% in-service ity clinical nurse to be completed f working beyond vet received the ed nurses on that the nary Form is of transfers with Policy provided in	
	resident. During an interview v	with the Administrator on she stated the facility was		<ol> <li>The Facility Adminis audits via the Notificatio 100% of residents transi</li> </ol>	strator will conduct n Audit tool of	

Facility ID: 943195

If continuation sheet Page 11 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/24/2018 MAPPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345412	B. WING			03	8/21/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BRANTW	OOD NH & RETIREMENT	CENT			038 COLLEGE STREET XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 625	not providing a bed h responsible parties w but this would be corr During a family interv the family member st received any type of I Resident #5 was tran 1/30/18 and 3/6/18. Example 2. Resident #38 was ad 7/28/17 and re-admitt 2/3/18 and 3/7/18 wit chronic gastrointestin was transferred to the 1/3/18, 1/11/18 and 3 Review of Resident # data set assessment cognitively intact. Review of Resident # member was the resp During an interview w 3/19/18 at 9:07 AM h Resident #38 had had admissions since Jan gastrointestinal bleed received any paperwa transfers. During an interview w 3/20/18 at 10:02 AM f responsible party was Hold policy on admissi unaware that a Bed F	old notice to residents or then a resident transferred rected immediately. iew on 3/20/18 at 11:00 AM ated that she had not bed hold notice when sferred to the hospital on mitted to the facility on ted on 1/9/18, 1/14/18, h diagnoses including hal bleeding. Resident #38 e hospital on 12/26/17, //20/18. 38's most recent minimum dated 11/19/17 as 38's chart revealed a family ponsible party. with the family member on e stated he visited daily and d multiple hospital	F	525	facility to ensure that this system is effective weekly x 8 weeks, bi-weekl weeks, then monthly x 2 months. An concerns will be immediately addres by the medical record manager, Pati Care Coordinator and Director of Act with re-education of the pertinent sta during the time of the audit. The Administrator will compile the results the Notification Audit Tool and present the Executive Quality Improvement Committee monthly x 5 months. Identification of trends will determine need for further action and/or change frequency of required monitoring.	y sed ent ivities ff of nt to the	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345412	B. WING			03/21/2018		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BRANTWOOD NH & RETIREMENT CENT					1038 COLLEGE STREET OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)				(X5) COMPLETION DATE	
F 625	the resident transferrers stated she usually cal she was made aware admitted to the hospit had always had enou- resident. During an interview w 3/20/18 at 10:30 AM s not providing a bed he responsible parties w but this would be corr Example 3. Resident #68 was add 11/21/17 and re-admi 1/11/18 with diagnose Urinary tract infection was transferred to the 1/8/18. Review of the admiss assessment dated 11 #68 as having long ar problems and severed During an interview w 3/20/18 at 10:02 AM s responsible party was Hold policy on admiss unaware that a Bed H given to the resident of the resident transferrers stated she usually cal she was made aware	ed to the hospital. She lled the family member once the resident would be tal. She stated the facility gh beds to re-admit a with the Administrator on she stated the facility was old notice to resident's or hen a resident transferred rected immediately. mitted to the facility on tted on 12/19/17 and es including Dementia, and femur fracture. She e hospital on 12/25/17 and ion minimum data set /28/17 identified Resident hd short term memory ly cognitively impaired. with the Social Worker on she stated the resident or a given a copy of the Bed sion. She stated she was fold notice needed to be for responsible party when ed to the hospital. She lled the family member once the resident would be tal. She stated the facility	F	62	5			

If continuation sheet Page 13 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345412	B. WING			03/	21/2018
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRANTWOOD NH & RETIREMENT CENT					1038 COLLEGE STREET DXFORD, NC 27565		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page resident.	9 13	F	625	5		
	3/20/18 at 10:30 AM s not providing a bed h	with the Administrator on she stated the facility was old notice to residents or hen a resident transferred rected immediately.					
	12/14/15 and re-admi re-admitted on 1/18/1 Heart Failure, Hyperte Accident, Dementia a	8 with diagnoses including ension, Cerebral Vascular nd Chronic Obstructive He was transferred to the					
		34's most recent Minimum 4/17 identified Resident # 34 vely impaired.					
	A review of Resident indicated Resident # 5 friend.	# 34's medical record 34's responsible party was a					
	3/20/18 at 10:02 AM s responsible party was Hold policy on admiss unaware that a Bed H given to the resident of the resident transferre stated she usually cal	with the Social Worker on she stated the resident or s given a copy of the Bed sion. She stated she was hold notice needed to be for responsible party when ed to the hospital. She lled the family member once the resident would be					

Facility ID: 943195

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		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION UMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED	
	345412				03/21/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
BRANTWO	OOD NH & RETIREMENT	CENT		1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECT       EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOUL       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPRO DEFICIENCY)		D BE COMPLETI	
F 625	admitted to the hospit had always had enou resident.	al. She stated the facility gh beds to re-admit a	F 62	5	
F 677	3/20/18 at 10:30 AM s not providing a bed he responsible parties w but this would be corr A phone interview wa 34's responsible party with a message left to resident's representat	s attempted with Resident # / on 3/21/18 at 10:35 AM	F 67	7	4/18/18
SS=D	§483.24(a)(2) A resid out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on medical re and interview the faci bath for 1 of 8 (Reside	ent who is unable to carry iving receives the necessary good nutrition, grooming, and liene; is not met as evidenced cord review, observation lity failed to provide a bed ent #116) residents requiring istance with Activity of Daily		1. Resident #116 was bathed on 03/19/2018 and will continue to be to per her preference by facility staff and placed on facility beauty shop sched for 3/26/2018. The current system for bather predicate involves a cabady	nd dule or
	2/2/18 with diagnoses obstructive pulmonary was on hospice. A review of her most	was admitted to the facility on gnoses of cellulitis, chronic monary disease, osteoporosis and		bathing residents involves a schedu resident baths by shift. It was identifi that this schedule was not adhered which placed the nurse aide behind schedule causing her to provide bat assistance to a resident later than preferred. The schedule will be adju using identified resident preferences NA #1 was addressed appropriately regarding the deficient practice.	fied to, thing isted s and

Facility ID: 943195

If continuation sheet Page 15 of 22

		MEDICAID SERVICES			OMB NO. 0938-0
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345412		· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING		03/21/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
BRANTWOOD NH & RETIREMENT CENT				1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPLETI TO THE APPROPRIATE DATE
F 677	Continued From page	e 15	F 67	77	
1 011	cognitively intact and		107	2.The facility patient car	e coordinator
		red extensive assistance		director of activities and	
		g, personal hygiene and was		office manager will cond	-
	totally dependent on			interviews with all alert a	
				residents within the facil	ity to determine
		ent's care plan updated on		their shift bathing preference	
		had an ADL self-care deficit.		resident #116 to ensure	Ū.
		ze self with resident ' s		assistance occurs at a ti	
	treatments.			needs for the residents. preferences were utilize	
	A review of the care a	area assessment (CAA)		shift assignment sheets	
	dated 2/8/18 revealed			residents preferences.	
	required assistance w			3. A 100% in-service wa	
				facility clinical nurse ma	-
		M the resident was observed		3/21/2018 for all certified	•
		ed and in a hospital gown.		assistants, including NA	
		hat she had been waiting for		resident s ADL needs to	5
	wished her hair was o	t that her hair was dirty and		residents requiring exter with the expectation of r	
				clinical manager of all ba	
	On 3/19/18 at 02:28 F	PM, the resident's nursing		preferences that contract	•
		ed that she had 17 residents		established bathing sch	
		nad not gotten to Resident		assignment sheets. The	
	-	ed that she did not know		completed by 4/6/2018	
	when the resident's h	air was last washed.		working beyond this date	
	<b>.</b>			yet received the educati	
	-	vith the Administrator and		certified nursing assistant	
		03:10 PM, NA#1 stated that on the 200 hall and that		educated during orientation resident ADL assistance	0
		upposed to receive a bed		ensuring that their bathi	
		she just had too many		occurs per the bathing s	-
	residents and could n			meets the resident s Al	
		that NA#1 had someone to		needs and preferences.	
		ld have asked for help. The		4. When providing bathing	-
		stated that NA#1 had only		resident, to include resid	
	-	oaths on 1st shift and should		certified nursing assistan	
	have bathed Residen	it # i to earlier.		their bathing assistance bathing schedule that m	-
				resident s ADL assistar	

Event ID: J92511

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/24/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345412				03/21/2018
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRANTW	OOD NH & RETIREMENT	CENT		1038 COLLEGE STREET OXFORD, NC 27565	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETION
F 677 F 690 SS=D	CFR(s): 483.25(e)(1) §483.25(e) Incontiner §483.25(e)(1) The factor resident who is continent admission receives some maintain continence of	tinence, Catheter, UTI -(3) nce. cility must ensure that hent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain.	F 67	preferences. The patient care coord director of activities and facility busi office manager will conduct bathing on 10% of all dependent residents, include resident #116, utilizing a Re Bathing Audit Tool 5 x week x 4 wee weekly x 4 weeks then monthly x 2 months to ensure staff are providing bathing assistance per the bathing schedule that meets the resident as assistance needs and preferences. concerns will be immediately addre by the Clinical Nursing Manager, Ni Educator, MDS Coordinator, and Treatment Nurse with reeducation of during the time of the audit. The DO review and initial the audit tool wee weeks then monthly x 2 months to a compliance. The DON will compile results of the Resident Bathing Aud and present to the Executive Qualit Improvement Committee monthly x months. Identification of trends will determine the need for further actio and/or change in frequency of requ monitoring.	iness audits to essident eks, g s ADL Any ssed ursing of staff DN will kly x 8 ensure the lit Tool y 4

Facility ID: 943195

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 04/24/20 <sup>,</sup> 1 APPROVE . 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345412	B. WING		03/2	21/2018
NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT				STREET ADDRESS, CITY, STATE, ZIP COD	E	
				1038 COLLEGE STREET OXFORD, NC 27565		
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETIO DATE
F 690	Continued From pag	e 17	F 69			
	incontinence, based		1 030			
		essment, the facility must				
	ensure that-					
		ters the facility without an				
	indwelling catheter is	s not catheterized unless the				
	resident's clinical cor	ndition demonstrates that				
	catheterization was r					
		nters the facility with an				
	-	r subsequently receives one				
		oval of the catheter as soon ne resident's clinical condition				
		atheterization is necessary;				
	and					
		incontinent of bladder				
	. ,	treatment and services to				
	prevent urinary tract	infections and to restore				
	continence to the ext	tent possible.				
	§483.25(e)(3) For a r	resident with fecal				
	incontinence, based	on the resident's				
		ssment, the facility must				
		nt who is incontinent of bowel				
		treatment and services to				
		mal bowel function as				
	possible.	T is not met as evidenced				
	by:					
	,	ecord review, observation		1. Resident #29□s Foley ca	atheter was	
		ility failed to ensure a		observed lying on the floor. T		
		eter bag was secured in a		resident s catheter was remo		
		m lying on the floor and		the floor and concealed via a	-	
		ty of disease and infection		catheter covering immediately		
		s observed with urinary		identification to ensure that th		
	indwelling catheters	(Resident #29).		was in the appropriate placen lying on the floor and promoti		
	Findings included			possibility of disease and infe resident.	-	
	Resident #29 was ac	mitted to the facility on		2. This resident is 1 of 2 res	sidents within	
		d on 1/13/18 with diagnoses		the facility with a catheter, the	erefore the	

Event ID: J92511

Facility ID: 943195

If continuation sheet Page 18 of 22

(X3) DATE SURVEY COMPLETED 03/21/2018 RECTION (X5) HOULD BE PPROPRIATE COMPLETI DATE
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SHOULD BE COMPLETI
SHOULD BE COMPLETI
assessed
3/20/2018
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sibility of sident with
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is date who
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orientation htrol
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appropriate
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Facility ID: 943195

If continuation sheet Page 19 of 22

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 04/24/201 ORM APPROVEI 3 NO: 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION JILDING		DATE SURVEY COMPLETED
	345412		B. WING				03/21/2018
NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 690 F 725 SS=D	Sufficient Nursing Sta CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the f at §483.35(a)(1) The fac by sufficient numbers	aff (2) Staff. e sufficient nursing staff with vetencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care		725	staff are providing bathing assista ensure that their catheter is cover- placed in a way that promotes dig infection control for the resident. A concerns will be immediately addr by the Clinical Nursing Manager, I Educator, MDS Coordinator, and Treatment Nurse with re-education during the time of the audit. The D review and initial the audit tool we weeks then monthly x 2 months to compliance. The DON will compile results of the Resident Bathing Au and present to the Executive Qual Improvement Committee monthly months. Identification of trends wi determine the need for further act and/or change in frequency of req monitoring.	ed and nity and ny ressed Nursing n of staff OON will ekly x 8 o ensure e the idit Tool lity x 4 li ion	4/18/18

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/24/2018 RM APPROVEI O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345412	B. WING			03	3/21/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	OOD NH & RETIREMEN	CENT		10:	38 COLLEGE STREET		
DRANTW	JOD NH & RETIREMEN	I CENT		0)	(FORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From page	e 20	F 7	25			
20		sidents in accordance with		23			
	resident care plans:	sidents in accordance with					
		ed under paragraph (e) of					
	this section, licensed						
	(ii) Other nursing per	sonnel, including but not					
	limited to nurse aides	3.					
		section, the facility must nurse to serve as a charge					
	This REQUIREMENT	Γ is not met as evidenced					
	by: Decod on obconvotio	no record review and staff			1. Resident #116⊡s ADL needs we		
		ons, record review and staff failed to provide sufficient			addressed on 3/19/2018 by NA #1. Ir	-	
	-	bed bath for 1 of 8 residents			order to address the competency and		
		uiring total assistance with			set deficit, this staff member was		
	activities of daily livin	-			encouraged to ask for assistance as		
	The findings included	1:			needed and in-serviced on the expectation that all staff are to adher their daily bathing schedule, unless	e to	
	This tag is cross refe				otherwise requested by the resident, order to promote productivity during a		
		ns, record review and staff			given shift.		
	-	failed to provide sufficient			2. 100% of all staff to include licens		
		bed bath for 1 of 8 residents uiring total assistance with			nursing staff, certified nursing assista to include NA #1 are to be in-serviced		
	activities of daily livin	-			the clinical nurse manager and/or fac	-	
		5			Director of Nursing regarding the		
	A review of the reside	ent's care plan updated on			expectation of adhering to the establi	shed	
	2/21/18 revealed she	e had an ADL self-care deficit.			bathing schedule designated via the assignment sheets per shift in order	ho	
	A review of the care :	area assessment (CAA)			improve productivity to ensure that the		
	dated 2/8/18 revealed	· · · · ·			staff meet the residents a needs.	~	
	required assistance v				In-service initiated on 3/30/18 to be		
					completed by 4/6/18. All newly hired		
		M the resident was observed			will be educated regarding this system	m	
		ed and in a hospital gown.			upon hire, before working with the		
	The resident stated t	hat she had been waiting for			resident population within the facility.		

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STATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) I	NO. 0938-039 DATE SURVEY COMPLETED
			A. BUILDING			
345412		B. WING			03/21/2018	
NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT				STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				1038 COLLEGE STREET OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From page	e 21	F 72	25		
	her bed bath and that wished her hair was of On 3/19/18 at 02:28 F assistant (NA#1) state assigned to her and F #116 yet. NA #1 state when the resident's h During an interview w NA#1, on 3/20/18 at 0 she had 17 residents Resident #116 was st bath on first shift but a residents and could n Administrator stated t help her and she cou Administrator further 10 residents to give b	A VAL & RETIREMENT CENT SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 21 er bed bath and that that her hair was dirty and ished her hair was cleaned. In 3/19/18 at 02:28 PM, the resident's nursing sistant (NA#1) stated that she had 17 residents signed to her and had not gotten to Resident 16 yet. NA #1 stated that she did not know hen the resident's hair was last washed. uring an interview with the Administrator and A#1, on 3/20/18 at 03:10 PM, NA#1 stated that he had 17 residents on the 200 hall and that esident #116 was supposed to receive a bed ath on first shift but she just had too many isidents and could not get to her. The dministrator stated that NA#1 had someone to belp her and she could have asked for help. The dministrator further stated that NA#1 had only 0 residents to give baths on 1st shift and should ave bathed Resident #116 earlier.		3. The patient care coordin of activities and facility busin manager will conduct bathing 10% of all dependent resident resident #116, utilizing a Res Audit Tool 5 x week x 4 week weeks then monthly x 2 mon staff are providing bathing as the bathing schedule that me resident s ADL assistance r preferences. Any concerns w immediately addressed by th Nursing Manager, Nursing E Coordinator, and Treatment re-education of staff during th audit to ensure that the staff the established system for pur residents with assistance for DON will review and initial th weekly x 8 weeks then mont months to ensure compliance will compile the results of the Bathing Audit Tool and prese Executive Quality Improveme Committee monthly x 4 mont Identification of trends will de need for further action and/o frequency of required monito	ess office g audits on hts, to include sident Bathing s, weekly x 4 ths to ensure sistance per sets the needs and vill be e Clinical ducator, MDS Nurse with he time of the are following oviding ADLs. The e audit tool hly x 2 e. The DON e Resident nt to the ent ths. stermine the r change in	

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